MISSISSIPPI DIVISION OF MEDICAID

MS COOL KIDS (EPSDT)

SCHOOL HEALTH-RELATED SERVICES GUIDE

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MS Cool Kids (EPSDT) School Health-Related Services

INTRODUCTION

This MS Cool KIDS (EPSDT) guide is for school-based providers of expanded/health-related services for Medicaid eligible children with disabilities or special needs as defined in IDEA (Individuals with Disabilities Education Act), that are identified through the IEP (Individualized Education Plan) or the IFSP (Individualized Family Service Plan) process and determined to be medically necessary. The services outlined in this guide are for a targeted population.

COVERED SERVICES

Health-related services covered by Medicaid for eligible beneficiaries with disabilities as indentified in the child's individual IEP or IFSP between the ages of three (3) to twenty one (21) include the following:

1. Audiology Services
2. Medical Services
3. Occupational Therapy Evaluations and Treatment Services (OT)
4. Physical Therapy Evaluation and Treatment Services (PT)
5. Psychological Evaluations and Psychotherapy Services
6. Speech and Language Evaluations and Therapy Services (ST)
7. Transportation

ENROLLING AS A SCHOOL HEALTH-RELATED PROVIDER

To enroll in the Mississippi Medicaid Cool Kids (EPSDT) School Health-Related Services Program, school districts and/or school cooperatives, must complete the enrollment requirements and must sign a School Health Related Services agreement with DOM. An individual who is authorized to execute contracts on behalf of the school district must sign all required sections in both documents. In addition to completing enrollment requirements and signing a School Health Related agreement an individual school provider must have **servicing providers** attached to their school denoting who will be providing services to Medicaid beneficiaries. All **servicing providers**, whether on contract or employed by the school, must meet specific provider requirements for the MS Medicaid program. Each servicing provider must be separately qualified and enrolled as a Medicaid Provider and must have a separate provider number for their individual specialty.

The servicing provider will not be required to bill Medicaid. Only the school district will be required to bill and receive reimbursements. If after the initial application process is completed there are additional servicing providers, the school district must submit the names for each individual who will be providing services along with required documentations. All information must be on file with DOM prior to providing services.

Copies of the Mississippi Medicaid provider application and agreement are available by request from DOM's fiscal agent. Provider may obtain an application by calling 1-800-884-3222 or by accessing the website at https://msmedicaid.acs-inc.com/msenvision The Provider Enrollment Package may be downloaded under the Provider tab. Upon approval the provider will receive written notification from the fiscal agent. The notification will include the approval start date and the provider number for claims reimbursement.

Provider Preparation: On-Site

An on-site introduction and review of program requirements with the School Facility must be conducted prior to receiving the EPSDT School Health-Related provider segment.

PROGRAM REQUIREMENTS

The MS Cool Kids (EPSDT) School Health-Related Services Program was designed to identify children who have a learning difficulty due to a medical disability which requires special services. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 199 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medically necessary services provided to children under IDEA through a child's IEP or IFSP.

Medicaid will cover services included in an IEP or IFSP as long as the following criteria are met:

1. The services are deemed medically necessary and included under a Medicaid coverage category.
2. All other Federal and State regulations are followed, including those for provider qualifications.
3. The services are included in the State Plan or available under the MS Cool Kids (EPSDT) program.

The following documents should be collected prior to providing services and maintained in the clients file:

Prior Authorizations Approval (Treatment Authorization Number)

Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)

Parental Consent to treat

Parental consent to bill third parties (including Medicaid)

Provider qualifications (licenses or certification)

Dates of services

Provider of services a provider of Medicaid services.

Place of services

Length of time for services (if relevant)

Progress notes/reports

All of these documents are important to have in the event of an audit. They will also be helpful in the event it is necessary to adjust rates in the future.

All records must be maintained for a minimum of five years from the date of service or until all audit questions, appeal hearings, investigation or court cases are resolved. Federal guidelines governing public education require records to be stored for seven years. Records can be stored in any readily accessible location and format.

PRIOR AUTHORIZATION

OUTPATIENT THERAPY SERVICES

Prior Authorization (PA) or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify all outpatient therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. Providers should be aware that the frequency of visits provided by the therapist should match the Plan of Care signed by the physician. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

The PA number can be obtained from the Division of Medicaid UM/QIO contractor, who is currently Health Systems of Mississippi (HSM). Providers may contact HSM either by mail, fax, or via website.

Health Systems of MS

175 East Capitol Street, Suite 250

Jackson, MS 39201

601-360-4949 (local)

1-866-740-2221 (Toll-Free)

1-888-557-1920 (Fax)

www.hsom.org e-mail address

PSYCHOLOGICAL AND AUDIOLOGICAL SERVICES

The Service Checklist has been developed for the purpose of pre-certifying Psychological and Audiological services. A completed Service Checklist for each child who will receive Psychological and Audiological Services in the school setting and receive Medicaid reimbursing must be submitted to: (see page 17)

Division of Medicaid

550 High Street Suite 1000

Jackson, MS 39201-1399

601-359-6147 (fax)

ELIGIBILITY VERIFICATION

Permanent ID cards are issued to eligible Medicaid clients. At the beginning of each school year the provider should obtain a copy of the child's Medicaid card. DOM's fiscal agent has installed an Audio Voice Response System using automated response technology to give Mississippi Medicaid providers free access to eligibility information by entering beneficiary Medicaid number or social security number that bases eligibility verification on the date of service. Information concerning the eligibility of an individual may be obtained from the eligibility swipe card device, or by calling the Automated Voice Response System (AVRS) at 1-800-884-3222 or through ACS Provider and Beneficiary Services. The AVRS system is designed to allow you to verify eligibility by using your touchtone telephone. AVRS cannot be accessed with a rotary dial telephone.

Timely Billing Medicaid

Timely billing for services is essential. It is recommended that school districts bill within (30) days of the date of service. However, you must bill for all services within 12 months of the date services.

DESCRIPTION OF SERVICES

SPEECH/LANGUAGE SERVICES

Outpatient speech-language pathology services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed, physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services (speech therapy) must be provided by a state-licensed speech-language pathologist.
- Services provided by speech-pathology assistants and/or aides are not covered.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e.,
- Only a state-licensed speech-language pathologist may evaluate, plan care, and deliver speech-language pathology therapy services.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

A list of therapy services **not** covered/reimbursed by the Division of Medicaid may be found in Section 49.03 of the Provider Policy Manual.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Section 49.09 of the Provider Policy Manual.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Please refer to the Provider Policy Manual Section 49 Speech/Language Services

OUTPATIENT OCCUPATIONAL THERAPY

Outpatient Occupational Therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed, physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services (speech therapy) must be provided by a state-licensed Occupational Therapist.
- Services provided by Occupational Therapist assistants and/or aides are not covered.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e only a state-licensed occupational therapist may evaluate, plan care, and deliver occupational therapy services.
- Services must be conducted one-on-one (beneficiary and therapist). Group occupational therapy
- is not covered.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

A list of therapy services **not** covered/reimbursed by the Division of Medicaid may be found in Section 48.03 of the Provider Policy Manual.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Section 48.09 of the Provider Policy Manual.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Please refer to the Provider Policy Manual Section 48 Outpatient Occupational Therapy

OUTPATIENT PHYSICAL THERAPY

Outpatient Physical Therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed, physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services (physical therapy) must be provided by a state-licensed Physical Therapist.
- Services provided by Physical Therapist assistants and/or aides are not covered.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- Services must be conducted one-on-one (beneficiary and therapist).
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

A list of therapy services **not** covered/reimbursed by the Division of Medicaid may be found in Section 47.03 of the Provider Policy Manual.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Section 47.09 of the Provider Policy Manual.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Please refer to the Provider Policy Manual Section 47 Outpatient Physical Therapy.

PSYCHOLOGICAL SERVICES

Psychological evaluation includes a battery of tests, interviews and behavioral evaluation that appraise cognitive, emotional and social functioning and self concept. These services must be provided by a licensed psychiatrist or licensed clinical psychologist. The standard tests listed below must be used, when appropriate. The procedure code for psychological evaluation is listed below. The child may have one evaluation per year.

96100 Unit Limit-4units per year 1unit = 1 hour

Adaptive Behavior Inventory for Children
AAMD Adaptive Behavior
Scale Alpern-Boll Developmental
Inventory Battelle Developmental
Inventory Bender Visual Motor
Gestalt Test Brigance Kindergarten
Screening Burks Behavior Raging
Scales Catellinfant Intelligence
Scale Children's Appreciation Test
Cognitive Observation Guide
Columbia Mental Maturity Scale
Functional Profile Psycho-Diagnostic Tests Rorschach
Projective Technique Raven
Progressive Matrices Sentence
Completion Test
Test of Visual
Perceptual Skills Ugziris-Hunt
Ordinal Scales of Infant
Development Wechsler
Intelligence Scale for Children-III
Behavior Rating Inventory for Autistic and Other Atypical Children
Developmental Test of Visual Motor Integration
Gilmore Oral Reading Test Inventory of Reading Mastery Test
Woodcock Reading Mastery Test Kaufman
Assessment Battery for Children
Wide Range Achievement Test Key
Math Diagnostic Arithmetic Test
Westby Play Scale Largo and Howard Play Assessment Test of Nonverbal Intelligence
Leiter International Performance Scale
Projective Drawings McCarthy Scales of Children's Abilities
Merrill Palmer Scale of Mental Abilities
Motor-Free Visual Perception Test
Nonverbal Test of Cognitive Skills

Peabody Picture Vocabulary Test-Revised
Thematic Appreciation Test (TAT)
Wechsler Adult Intelligence Scale-Revised
Wechsler Preschool and Primary Scale of Intelligence-Revised
Frosty Development Test of Visual Motor Integration
Hiskey-Nebraska Test of Learning Aptitude

PSYCHOTHERAPY SERVICES

Therapy/treatment means planning, managing and providing a program of psychological services including counseling for children with psychological problems. Below is listed the covered procedure codes for psychotherapy.

90804
90806
90808

AUDIOLOGICAL EVALUTION

Please refer to Provider Policy Manual Section 76.07 EPSDT School Health Related Services – Audiological Services

CERTIFICATION OF PUBLIC FUNDS

The Division of Medicaid **requires all School Health-Related Services (SHRS)** providers to submit the Certification of Public Funds letter at the **end of each quarter** of the state fiscal year to the Division of Medicaid. The purpose of the letter is to verify the amount identified as "State/local Funds" has been spent by the school district for the quarter as noted on the letter. By signing the letter, the SHRS provider is certifying that state and/or local funds were expended in at least the amount listed on the letter, thereby allowing the school district to receive the federal matching reimbursement from the Division of Medicaid. **At the beginning of the state fiscal year**, the Division of Medicaid requires the SHRS provider to submit the Certification of Budgeted Funds statement which lists the budgeted amount of "State/local Funds" expected to be utilized for the purpose of providing School Health-Related Services. The Certification of Budgeted Funds letter should be submitted within ten (10) days of the start of the state fiscal year. The letters must be signed and returned to the following address:

Division of Medicaid

Bureau of Maternal and Child Health

Attn: Jakki Andrews

550 High Street, Suite 1000

Jackson, MS 39201-1399

The individual signing the letter must be the person responsible for signing other documents subject to audits. The letter must be returned within ten (10) days of receipt. If you require assistance with the letter, contact the School Health Program within the Bureau of Maternal and Child Health at 601359-6150.

Validating the Record

Any budgeted expenditures that can be traced back to the specific SHRS can be used to validate state and local funds expenditures. The most common and easiest ways to track expenditures are salaries and fringe benefits. Other expenditures could include capital outlay, supplies and materials and travel.

Record Keeping

The following information must be kept in the school district records in order to validate the certification of funds:

- Identify the source of funds used to pay for the costs (such as salaries) of delivering the services contained in claims being examined. This would be necessary in order to document that an adequate amount of state or local funds were expended to obtain federal match and that no federal funds were used for matching purposes; and
- Document that the state and local funds certified were actually expended for the purpose of providing SHRS. For example, payroll records would reveal that staff providing the SHRS had been paid from funds using an adequate amount of state and local funds.

SUMMARY OF MONITORING AND DOCUMENTATION

The Monitoring and Review process involves the school provider making available to the Division of Medicaid all records of MS COOL KIDS (EPSDT) health related services provided to Medicaid eligible children. The following documentation must be maintained for at least seven years from the date of payment on all children for whom claims have been submitted.

1. The dates and results of all evaluations or the diagnosis provided in the interest of establishing or modifying an IEP or IFSP, including the specific tests performed and copies of evaluation and diagnostic assessments report signed by the individual and supervisor, if appropriate, that administers the test or perform the assessment.
2. Copies of the IEP or IFSP documenting the need for the specific therapy or treatment services, the time and frequency required for each service.
3. Documentation of the provision of treatment services by individual physicians, therapists and other qualified professionals including the dates of services, billing forms, log books, reports on services provided and the child's record (s) signed by the individual providing the services and the signature of the supervisor, if appropriate.
4. Copy of Prior Authorization Treatment Authorization notification or Service Checklist.
5. Documentation of appropriate certification, licensed, education and/or training and supervision of professional staff providing services.

MS COOL KIDS (EPSDT)

SCHOOL HEALTH RELATED SERVICES

Date Submitted:_____ Date of IEP or IFSP:_____

SERVICE CHECKLIST

PROVIDER INFORMATION

Name of School: _____

School Provider Number: _____

Servicing Providers: _____

Contact Person: _____

Phone Number: _____

MEDICAL DATA

A. PRIMARY DIAGNOSIS: _____

B. SECONDARY DIAGNOSIS: _____

C. EXPECTED LENGTH OF TREATMENT: _____

D. SIGNIFICANT PROBLEMS/JUSTIFICATION: _____

_____

_____

PATIENT INFORMATION

Name of Beneficiary:_____

Medicaid Id Number:_____

DOB:_____ Sex: _____M _____F

Family or Responsible Party (name, address or phone#):

_____

_____

_____

Third Party Coverage: _____Yes _____No

PROCEDURE CODE:	UNITS:	
90804		
90806		
90810		
96100		
V5000		

Are these services being referred as a result of a MS COOL KIDS (EPSDT) Screening? _____Yes _____ No

Person completing this form must verify with signature that all applicable documentation are on file:

1. Parental signature for permission to treat on file: _____
2. Parental signature for permission to bill Third Party Insurance on file: _____
3. Parental signature for permission to bill Medicaid on file: _____
4. Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) on file: _____
5. Services requested above are consistent with the IEP or IFSP: _____
6. Physician referral for psychological, psychotherapy on file: _____
7. Services will be provided only by those qualified providers listed: _____

_____

All Service Checklists Should be Mailed to:

Division of Medicaid

Walter Sillers Suite 1000

550 High Street, Jackson, MS 39201-1399

SCHOOL HEALTH RELATED CONTACTS

Division of Medicaid
Bureau of Maternal and Child Health Services
550 High Street, Suite 1000
Jackson, MS 39201-1399
Jakki Andrews, Program Administrator
Phone: 601-359-6811
Fax: 601-359-6147
epjla@medicaid.state.ms.us – email

Prior Authorization Questions
Health Systems of MS
175 East Capitol Street,
Suite 250, Lock Box #13
Jackson, MS 39201
Phone: 601-360-4949 Local and 1-866-740-2221, Toll-free
Fax: 1-888-557-1920

Provider Claims Services
ACS Provider Services
P.O. Box 23078
Jackson, MS 39225
1-800-884-3222